SUPERINTENDENT MEMORANDUMS

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P.O. BOX 2120
RICHMOND, VIRGINIA 23216-2120

SUPTS. MEMO. NO. 21
January 29, 1993

INFORMATIONAL

TO: Division Superintendents

FROM: Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction

Ernest W. Martin
Assistant Superintendent

SUBJECT: Legally Permissible Activities of Licensed Nurse Practitioners

The attached letter from the Virginia Commissioner of Health contains information about legally permissible activities of licensed nurse practitioners under the regulations of the state Boards of Medicine and Nursing.

For example, LNPs may substitute for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services such as homebound instruction for pregnant students.

If you have questions about the contents of the Commissioner's letter, please contact Doug Cox at the Department of Education, 804/225-2871.

JASjr/EWM/ao

Attachment (1)

COMMONWEALTH of VIRGINIA
Department of Health
P. O. BOX 2448
RICHMOND, VA 23218

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

December 10, 1992

Dr. Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction
101 North 14th Street
Monroe Building
Richmond, Virginia 23219

Dear Dr. Spagnolo:

I would like to request your dissemination of this letter to all Division Superintendents throughout the state informing them and their staff of the legality of licensed nurse practitioners (LNPs) substituting for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services, such as homebound instruction for pregnant students. Local health departments employ a large number of LNPs who perform these required examinations and authorizations and sign their names in the place designated for a physician. Some local school divisions have refused to accept the LNP's signature. We have also been made aware of similar problems with LNPs working with private physicians. Those LNPs also have the authority to perform these examinations.

Regulations of the Boards of Medicine and Nursing state that "a licensed nurse practitioner shall be authorized to engage in practices constituting the practice of medicine under the supervision and direction of a licensed physician" and that the practice shall be "in accordance with written protocols" approved by the supervising physician. These protocols uniformly authorize LNPs to perform physical examinations, to report the findings in writing and to sign the report as would be done by a physician. LNPs are also authorized to make referrals for community services such as homebound instruction when indicated for medical reasons.

The Virginia Department of Health interprets the code section 22.1-270 that requires the report of a preschool physical examination signed by a "qualified licensed physician" allows the report to be signed by a LNP. The Medicaid program accepts services performed by a LNP the same as by a physician. LNPs are now authorized to write prescriptions and school may staff

receive requests to administer medications prescribed by a LNP.

Because LNPs may legally perform all these functions that formerly required a licensed physician and because the supervising physician is frequently not available, especially in the health departments, we request that schools accept the signature of a LNP in place of the signature of a physician in all the instances mentioned and in similar situations. This will be a time saver for the schools, health departments, private physicians and parents.

Please let me know if you have any questions about this request.

Sincerely,

Robert B. Stroube, M.D., M.P.H.
State Health Commissioner

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 2120
RICHMOND, VIRGINIA 23218-2120

SUPTS. MEMO NO. 22
February 5, 1999

INFORMATIONAL

TO: Division Superintendents

FROM: Paul D. Stapleton

Superintendent of Public Instruction

SUBJECT: School Health Form HPE-hl2

The Department of Education distributes a number of School Health Forms to local school divisions. These School Health Forms are currently being reviewed by the Department of Health and the Department of Education.

The following form has been deleted: **FORM HPE-h12, THE SCHOOL ENTRANCE HEALTH INFORMATION FORM (DATED DECEMBER 1983).** The information on that form is provided in Part I, Health Information Section of the School Entrance Physical Examination and Immunization Certification, (MCH 213C) dated October 1991.

Should you have any questions or comments, please contact Gwen Smith, R.N., Student Health Services Specialist at (804) 786-8671 or e-mail gpsmith@pen.kl2.va.us.

PDS/gs

cc: Gwen Smith

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216-2060

SUPTS. MEMO NO. 137
June 19, 1992

INFORMATIONAL

TO: Division Superintendents

FROM: Joseph A. Spagnolo, Jr., Superintendent of Public Instruction

Edward W. Carr, Chief of Staff

SUBJECT: School Health Education Advisory Board

The 1992 General Assembly amended and reenacted § 22.1 - 275.1 to require each school division to have a school health advisory board. The advisory board should be organized to advise school divisions about the development and implementation of school health programs, including health instruction, the school environment and health services.

The school health advisory board should be organized to include no more than twenty (2O) members, with a broad base of representation including parents, students, health professionals and educators. In addition, the board may be organized to include representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education. Each advisory board is required to meet at least semi-annually and to provide an annual report on the status and needs of student health in the school division to any relevant school, the school board the Virginia Department of Health, and the Virginia Department of Education.

Please find attached a copy of the act to create the Iota} school health advisory boards. You will also find attached a plan which may be helpful in defining and organizing the work of the local school health advisory board. If you have any questions, please contact Mrs. Fran Meyer at 804/225-3210, Virginia Department of Education,

JASjr/EWC/ewh

Attachments

COMMONWEALTH of VIRGINIA

James W. Dyke, Jr.
Secretary of Education

Office of the Governor
Richmond 23219

(804) 786-1151
TDD (804) 786-7765

MEMORANDUM June 9, 1992

TO: ALL LOCAL SUPERINTENDENTS
ALL LOCAL SCHOOL BOARD CHAIRS

FROM: James W. Dyke, Jr.
James P. Jones, President, Board of Education
Joseph A. Spagnolo, Jr., Superintendent of Public Instruction

SUBJECT: Student Health Issues

In all of our discussions about educational goals, we have made it clear that in order for students to take full advantage of a "world class education", they must be ready to learn when they enter school and be healthy so they can concentrate on learning while they are in school.

In that regard, the Governor's Task Force on Child Health recommended that the Secretaries of Education and Health and Human Resources work together to encourage local school divisions to increase the school's role in improving the health of our children.

Secretary Dyke and Secretary of Health and Human Resources Howard Cullum have moved to implement that recommendation by agreeing that certain actions should be taken by each school division in Virginia. The purpose of this memorandum is to request that your division work to enact the following actions by the beginning of the 1992-93 school year:

1. All school divisions should take advantage of the federally-funded school breakfast program or a comparable program. Students cannot learn if they are hungry. This program offers students an opportunity to receive needed nourishment to give them energy during the school day. The program is funded by the federal government and it should be

ALL LOCAL SUPERINTENDENTS 2
ALL LOCAL SCHOOL BOARD CHAIR8
Student Health Issues
June 9, 1992

used by every school in Virginia. The Department of Education is prepared to assist localities that do not presently offer this program to have such a program in place by the start of the next school year.

2. School divisions should work towards having onsite health screening for children. Many children presently do not have access to health care. One way we are addressing this need is by our planning for pilot school-Community Health Clinics, funded through Medicaid. We encourage your individual efforts to make health screenings available, and we encourage you to work with us on our Medicaid pilot programs. In addition, consideration should be given to involvement with the federal Early end Periodic Screening, Diagnosis and Treatment Program, which supports screening and early intervention.
3. School buildings should be “smoke free” as well as “drug free.” Smoking in school buildings should be banned (or at least confined to · separate designated area). Treatment alternatives for those persons making the transition from smoking to non-smoking should be publicized. ·
4. School divisions should make available to students and their families information about locally available health services.
5. Schools should make every effort to have a medical staff person available to each building during school hours. This can be accomplished through creative approaches, including working with local businesses and medical organizations in e public/private partnership.
6. All school divisions should have in place by December 1992 the Health Advisory Councils required by the §22.1-275.1 end revised in Senate Bill 435. Further, these councils should be fully utilized to help develop community support for the health initiatives

schools need to implement in order to fully serve our students.

7. Review school food policies for the purpose of eliminating unhealthy Junk food and promoting the availability of nutritious, healthy food items. This applies to school cafeteria or food sales as well as vending machines which are accessible to students.
8. Review physical education policies to ensure that each student, from preschool to secondary school, participates in an appropriate end meaningful program geared toward physical fitness.
9. In recognition of the health, injury, and developmental problems associated with contact sports, the Governor’s Task Force on intercollegiate Athletics will be reviewing the appropriate age for students to begin involvement in interscholastic athletics. Superintendents should pay particular attention to the work of this task force in their review of the elementary and secondary school athletics.

We realize that school systems have full plates in terms of meeting standards and accomplishing goals, particularly in tight economic tines, we also, however, agree that we cannot afford to ignore the health needs of our students. Achieving world class education requires students ready to learn and that means healthy students. We end the Department stand ready to work with you to implement these initiatives.

JWDJr/JPJ/JASJr/pfc

cc: The Honorable Howard M. Cullum

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216

SUPTS. MEMO NO. 159
August 19, 1987

INFORMATIONAL

MEMO TO: Division Superintendents

FROM: S. John Davis
Superintendent of Public Instruction

E. B. Howerton, Jr., Deputy Superintendent
for Instruction and Personnel

SUBJECT: Procedures for Implementing School Law 22.1-273

At its April meeting, the Board of Education established procedures for implementing School Law 22.1-273 Sight and hearing of pupils to be tested. A copy of the procedures for implementation is attached.

Because all children are required to have a physical examination when they first enter school, it was determined that this requirement would provide adequate screening for kindergarten students. Therefore, the only health screening required to be done for pupils will be for sight and hearing defects in grades 3, 7, and 10. Schools will continue to use the current HPE-h-8 forms for recording their findings.

If you have any questions, please contact Bernard R. Taylor, director, Division of Sciences and Elementary Administration at 804/225-2865 or Jeane L. Bentley, associate director, Health, Physical Education, and Driver Education at 804/225-2866.

/tim

Attachment

IMPLEMENTATION OF SCHOOL LAW 22.1-273

PROCEDURES:

That sight and hearing of pupils in grades 3, 7, and 10 be screened within 60 administrative working days of the opening of school. Whenever a pupil is found to have any defect of vision or hearing or a disease of the eyes or ears, the principal shall notify the parent or guardian in writing, of such defect or disease.

This screening of pupils will be monitored through the administrative review process.

Practices That Are Encouraged:

That teachers at all grade levels be observant of speech defects, postural deviations, hearing impairments, dental defects, visual problems and significant deviations in height and weight. If observed, they should be recorded on health record and reported to the school nurse for follow-up.

That scoliosis screening be done for all students in grades 5 through 9.

Adopted Virginia Board of Education
April 1987

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216

SUPTS. MEMO. NO. 168
September 2, 1987

INFORMATIONAL

MEMO TO: Division Superintendents

FROM: S. John Davis
Superintendent of Public Instruction

E. B. Howerton, Jr., Deputy Superintendent
for Instruction and Personnel

SUBJECT: Procedures for Implementing School Law 22.1-273

Reference is made to Superintendent's Memorandum #159 (Informational) dated August 14, 1987, which provided guidance for school division personnel when implementing section 22.1-273 of the Code of Virginia.

Existing Board of Education regulations as specified in Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, September 1984 stipulate that:

> All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (a) speech, voice, and language; (b) fine and gross motor functions; and (c) vision and hearing.

Additional screening for vision and hearing should now occur in grades 3, 7, and 10. Schools should continue to use the current HPE-h-8 form for recording screening results.

Questions regarding this matter should be addressed to Ms. Jeane L. Bentley, Associate Director of Health, Physical Education, and Driver Education at (804) 225-2866 or Ms. Patricia A. White, Associate Director for Visiting Teacher/School Social Work, School Psychology and School Health Services at (804) 225-2072.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216

SUPTS. MEMO NO. 255
November 29, 1989

INFORMATIONAL

TO: Division Superintendents

FROM: S. John Davis, Superintendent of Public Instruction

E. B. Howerton, Jr., Deputy Superintendent for Curriculum, Instruction and Personnel Services

SUBJECT: Model Guidelines for School Attendance for Children with Human Immunodeficiency Virus

Attached is a copy of the Model Guidelines for School Attendance for Children with Human Immunodeficiency Virus. These guidelines were developed as a result of House Joint Resolution 1974 requiring that they be completed by December 1, 1989, in cooperation with the Department of Health and distributed after approval by Board of Education

House Joint Resolution 1974 also requires that each school board shall, by July 1, 1990, adopt guidelines for school attendance of children with human immunodeficiency virus. These guidelines must be consistent with the model guidelines for school attendance developed by the Board of Education. We would like to call to your attention that the charge for the Department of Education was to address school attendance of children with the HIV virus and not confidentiality which is governed by Title 32 of the Code of Virginia. Please send copies of the attached guidelines to your school board members. If you have any questions, please contact H. Douglas Cox, Director, Division of Pupil Personnel Services, at (804) 225-2861.

SJD/EBHJr/tim

Attachment

MODEL GUIDELINES FOR SCHOOL ATTENDANCE FOR CHILDREN WITH HUMAN IMMUNODEFICIENCY VIRUS

The _____ Public School Division will work cooperatively with the _____ Health Department to ensure compliance with Virginia Code 22.1-271.3 for school attendance of children infected with human immunodeficiency virus (HIV).

A. Students are expected to be in compliance with an immunization schedule (Article 2, 22.1-271.2); however, some required immunizations may be harmful to the health of the student who is HIV infected or has AIDS. Students who are HIV infected or have AIDS may get an exemption from complying with the requirements (Virginia Code 22.1-27.2, C). School personnel will cooperate with public health personnel in completing and coordinating immunization data, exemptions, and exclusions, including immunization forms.

B. Mandatory screening for HIV infection is not warranted as a condition for school entry. Upon learning a student is HIV infected or has AIDS, the superintendent will consult with the individual's family and physician or a health official from the local health department to determine whether the student is well enough to stay in school. Since it is known that HIV is not transmitted through casual contact, any student who is HIV infected will continue education in a regular classroom assignment unless the health status interferes significantly with performance. If a change in the student's program is necessary, the superintendent or designee, family, and physician or health official will develop an individual plan which is medically, legally, and educationally sound. If the HIV student is receiving special education services, the services will be in agreement with established policies.

C. Parents/guardians may appeal decisions for restriction or exclusion as determined by the school division's established procedures.

D. All persons privileged with any medical information about HIV infected students shall be required to treat all proceedings, discussions, and documents as confidential information. Individuals will be informed of the situation on a "Need to Know" basis with written consent of the parent/guardian.

E. Universal precautions for handling blood will be implemented within the school setting and on buses. To ensure implementation of the proper standard operating procedures for all body fluids, the guidelines from the Virginia Department of Health will be followed. Inservice training will be provided to all school personnel. Training will include local division policies; etiology, transmission, prevention, and risk reduction of HIV; standard operating procedures for handling blood and body fluids; and community resources available for information and referral. Periodic updates will be supplied through inservice or memoranda.

F. Comprehensive and age-appropriate instruction on the principal modes by which HIV is spread and the best methods for the reduction and prevention of AIDS are required to encourage the support and protection of the HIV infected student. To enhance school attendance, the school division will collaborate with public and private organizations in the provision of support services to HIV infected students.

Definitions of Terms Associated With Special Education Programs for Children With Disabilities

Note: The following definitions are from the *Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia* (1994), unless other wise noted. (These regulations were under revision at the time of development of this manual.)

Special Education

Special Education. Special education means specially designed instruction, at no cost to the parent, to meet unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals, and institutions and in other setting and instruction in physical education.

1. The term includes speech-language pathology or any other related service, if the service consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, and is considered 'special education' rather than a 'related service' under state standards.

2. The term also includes vocational education if it consists of specially designed instruction at no cost to the parent, to meet the unique needs of a child with a disability.

3. The terms in this definition are defined as follows:

a) 'At no cost' means that all specially designed instruction is provided without charge, but does not preclude incidental fees which are normally charged to nondisabled students or their parents as part of the general education program.

b) 'Physical education' means:

- The development of physical and motor fitness; fundamental motor skills and patterns; and skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).

- The term includes special physical education, adaptive physical education, movement education, and motor development.

c) 'Vocational education' means organized educational programs that are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree.

The definition of special education is a particularly important one. While a child may be considered to have a disability under other laws, he does not have a disability under these regulations unless he needs special education. If a child does not need special education, there can be no related services since the provision of a related service must be necessary for a child to benefit from special education.

Disabilities

Autism. Autism means "a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age 3, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences."

Deafness. Deafness means "a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects educational performance."

Deaf Blindness. Deaf Blindness means "concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind children."

Developmental Delay. Developmental delay means "a significant delay in one or more of the following areas of development for a child below age 8:

1. Cognitive ability.
2. Motor skills.
3. Social/adaptive behavior.
4. Perceptual skills
5. Communication skills.

Hearing Impairment. Hearing impairment means " an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but which is not included under the definition of 'deafness' in this section."

Mental Retardation. Mental retardation means "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance."

Orthopedic Impairment. Orthopedic impairment means "a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., club foot, absence of some member), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contracture)."

Other Health Impairment. Other health impairment means "having limited strength, vitality, or alertness due to health problems, such as a heart condition, tuberculosis, rheumatic fever, arthritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, attention deficit disorder/attention deficit hyperactivity disorder, or diabetes that are chronic or acute that adversely affect a child's educational performance."

Serious Emotional Disturbance. Serious emotional disturbance means:

1. A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, that adversely affects a child's educational performance.

    - An inability to learn which cannot be explained by intellectual, sensory, or health factors.

    - An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

    - Inappropriate types of behaviors or feelings under normal circumstances.

    - A general pervasive mood of unhappiness or depression.

    - A tendency to develop physical symptoms or fears associated with personal or school problems.

2. The term includes children who are schizophrenic, but does not include children who are socially maladjusted unless it is determined that they are seriously emotionally disturbed.

Severe and Profound Disability. Severe and profound disability means "individuals who have:

1. Have primary disabilities that severely impair cognitive abilities, adaptive skills, and life functioning.

2. May have associated behavior problems.

3. May have the high probability of additional and/or sensory disabilities.

4. Do require significantly more educational resources than are provided for children with mild and moderate disabilities in special education programs."

Specific Learning Disability. Specific learning disability means "a disorder in one or more of the basic psychological processes involved in understanding or in using languages, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage."

Traumatic Brain Injury. Traumatic brain injury means "an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, or motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma."

Visual Impairment. Visual impairment means "an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness."

Related Services and Other Definitions

Assistive technology. "Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device." The term includes:

1. The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;

2. Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by children with disabilities;

3. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices;

4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation programs;

5. Training or technical assistance for a child with a disability or, if appropriate, that child's family;

6. Training or technical assistance for professionals, employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life function of children with disabilities.

Audiology. Audiology means "services provided by a qualified audiologist and includes:

1. Identification of children with hearing loss.

2. Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing.

3. Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading) hearing evaluation, and speech conservation.

4. Creation and administration of programs for prevention of hearing loss.

5. Counseling and guidance of pupils, parents and teachers regarding hearing loss.

6. Determination of the child's need for group and individual amplification and fitting an appropriate aid and evaluating the effectiveness of amplification."

Counseling Services. Counseling Services means "services provided by qualified visiting teachers, social workers, psychologists, guidance counselors, or other qualified personnel."

Medical Services. Medical services means "services provided by a licensed physician to determine a child's medically related disability which results in the child's need for special education and related services."

Occupational Therapy. Occupational therapy means "services provided by a qualified occupational therapist or services provided under the direction of a qualified occupational therapist and includes:

1. Improving, developing, or restoring functions impaired or lost through illness, injury or deprivation.

2. Improving ability to perform tasks for independent functioning when functions are impaired or lost.

3. Preventing, through early intervention, initial or further impairment or loss of function."

Parent Counseling and Training. Parent counseling and training means "assisting parents in understanding the special needs of their child and providing parents with information about child development."

Physical Education. Physical education means:

1. "The development of:

    - Physical and motor fitness;
    - Fundamental motor skills and patterns; and
    - Skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).

2. The term includes special physical education, adaptive physical education, movement education, and motor development."

Physical Therapy. Physical therapy means "services provided by a qualified physical therapist or under the direction or supervision of a qualified physical therapist upon medical referral and direction."

Psychological Services. Psychological services includes "those services provided by a qualified psychologist or services provided under the direction or supervision of a qualified psychologist:

1. Administering psychological and educational tests and other assessment procedures;
2. Interpreting assessment results;
3. Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
4. Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
5. Planning and managing a program of psychological services, including psychological counseling for children and parents."

Recreation. Recreation includes:

1. "Assessment of leisure function.
2. Therapeutic recreation services.
3. Recreation program in schools and community agencies.

4. Leisure education."

Rehabilitation Counseling. Rehabilitation counseling services "means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability. The term also includes vocational rehabilitation services provided to students with disabilities by vocational rehabilitation programs funded under the Rehabilitation Act of 1973, as amended."

School Health Services. School health services means "services provided by a qualified school nurse or other qualified person."

Social Work Services. Social work services includes "those services provided by a qualified visiting teacher or social worker:

1. Preparing a social or developmental history on a child with a disability.

2. Group and individual counseling with the child and family.

3. Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school.

4. Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program."

Speech/Language Pathology. Speech/language pathology "includes:

1. Identification of children with speech or language disorders.

2. Diagnosis and appraisal of specific speech or language disorders.

3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders.

4. Provisions of speech and language services for the habilitation or prevention of communicative disorders.

5. Counseling and guidance of parents, children, and teachers regarding speech and language disorders."

Transition Services. Transition services means "a coordinated set of activities for a student, designed within an outcome-oriented process, that promotes moving from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities described must:

1. Be based on the individual student's needs, taking into account the student's preferences and interests

2. Include:

    a) The development of employment and other post-school adult living objectives.

    b) Instruction.

    c) Community experiences.

    d) If appropriate, acquisition of daily living skills and functional vocational evaluation.

Transition services for students with disabilities may be special education if they are provided as specially designed instruction, or related services if they are required to assist a student with a disability to benefit from special education. The list of activities above is not intended to be exhaustive."

Transportation. Transportation "includes:

1. Travel to and from school and between schools.

2. Travel in and around school building.

3. Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provided special transportation for a child with a disability."

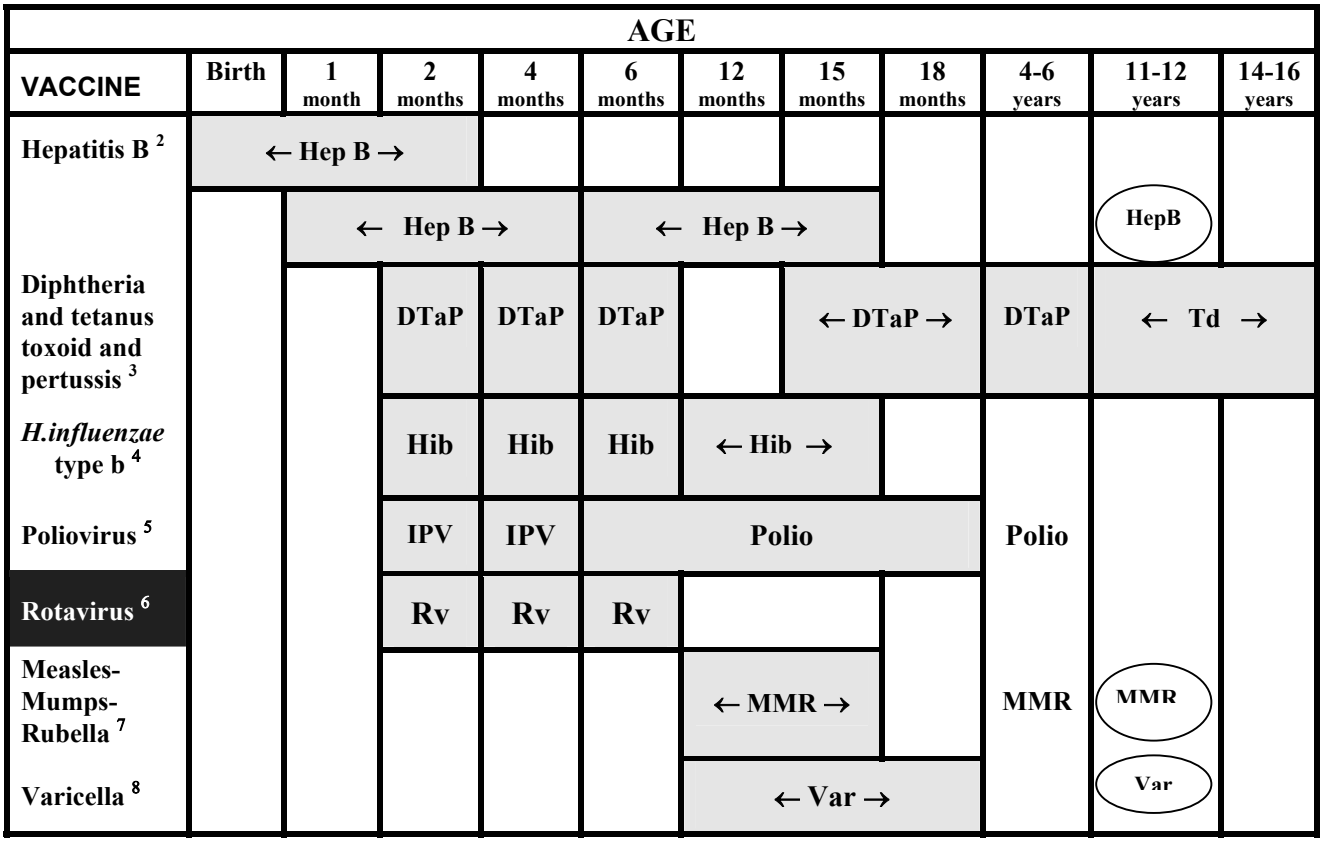
Vocational Education. Vocational education means "organized educational programs offering a sequence of courses or instruction in a sequences or aggregation of occupational competencies that are directly related to the preparation of individuals for paid or unpaid employment in current or emerging occupations requiring other than a baccalaureate or advanced degree. These programs must include competency-based applied learning that contributes to an individual's academic knowledge, higher-order reasoning, and problem-solving skills, work attitudes, general employability skills, and the occupation-specific skills necessary for economic independence as a productive and contributing member of society. This term also includes applied technology education."

Recommended Childhood Immunization Schedule

United States, January - December 1999

NOTE. The following table is from: CDC. (1999, January 15). Notice to Readers Recommended Childhood Immunization Schedule—United States, 1999. *MMWR 1999, 48*, 8-16.

Vaccines [1] are listed under the routinely recommended ages. Light shaded areas indicate the range of acceptable ages for vaccination. Circled areas indicate vaccines to be assessed and administered if necessary. Dark shaded area indicates the incorporation of this new vaccine into clinical practice may require additional time and resources from health-care providers.



[1] This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Any dose not given at the recommended age should be given as a "catch-up" vaccination at any subsequent visit when indicated and feasible. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2] **Infants born to hepatitis B surface antigen (HBsAg) -negative mothers** should receive the second dose of hepatitis B (Hep B) vaccine at least 1 month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before age 6 months. **Infants born to HBsAg-positive mothers** should receive Hep B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate injection sites. The second dose is recommended at age 1-2 months and the third dose at age 6 months. **Infants born to mothers whose HBsAg** status is unknown should receive Hep B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mothers HBsAg status; if the

HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). All children and adolescents (through age 18 years) who have not been vaccinated against hepatitis B may begin the series during any visit. Special efforts should be made to vaccinate children who were born in or whose parents were born in areas of the world where hepatitis virus infection is moderately or highly endemic.

[3] Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received one or more doses of whole-cell diphtheria and tetanus toxoids and pertussis vaccine (DTP). Whole-cell DTP is an acceptable alternative to DTaP. The fourth dose (DTP or DTaP) may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and if the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years .if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

[4] Three *Haemophilus influenzae* type B(Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2, 4, or 6 months unless approved by the Food and Drug Administration for these ages.

[5] Two poliovirus vaccines are licensed in the United States: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The ACIP, AAFP and AAP recommend that the first two doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of two doses of IPV administered at ages 2 and 4 months followed by two doses of OPV at age 12-18 months and age 4-6 years. Use of IPV for all doses also is acceptable and is recommended for immunocompromised persons and their household contacts. OPV is no longer recommended for the first two doses of the schedule and is acceptable only for special circumstances (e.g., children of parents who do not accept the recommended number of injections, late initiation of vaccination that would require an unacceptable number of injections, and imminent travel to areas where poliomyelitis is endemic. OPV remains the vaccine of choice for mass vaccination campaigns to control outbreaks of wild poliovirus.

[6] The first dose of Rv vaccine should not be administered before age 6 weeks, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at age 7 months, and all doses should be completed by the first birthday. The AAFP opinion is that the decision to use rotavirus (Rv) vaccine should be made by the parent or guardian in consultation with the physician or other health-care provider.

[7] The second dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at age 4-6 years but may be administered during any visit provided at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11-12 years.

[8] Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider] and who have not been vaccinated). Susceptible persons aged $\geq$13 years should receive two doses given at least 4 weeks apart.

Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

MINIMUM IMMUNIZATION REQUIREMENTS FOR ENTRY INTO CHILD CARE AND SCHOOL

NOTE: The following information is from the Commonwealth of Virginia, Virginia Department of Health, Division of Immunization, current as of April 1999.

For more information, please refer to the *Code of Virginia* 22.1-272, Immunization Requirements and Section 3.00 of the Rules and Regulations for the Immunization of School Children.

Upon entry or transfer into a child care or school setting, documentary proof shall be provided of adequate immunization with the prescribed number of doses of vaccine indicated below, **as appropriate for the child's age**:

DtaP, DTP. DT or Td - A minimum of 3 doses. A child must have at least one dose of diphtheria, tetanus, pertussis-containing vaccine after the fourth birthday. If the child has received six doses before the fourth birthday, additional doses are contraindicated. DT vaccine is required for children medically exempt from pertussis vaccine. Adult Td is required for children 7 years of age and older who do not meet the minimum requirements.

Polio - A minimum of 3 doses of OPV or IPV in any combination. If a child has had only 3 doses of polio vaccine, one dose must have been administered after the fourth birthday. However, e child who has received four does before the fourth birthday, is adequately immunized and does **not** need a dose after the fourth birthday.

Hib - This vaccine is required **only** for children up to 30 months of age. A complete series consists of either 2 or 3 doses (depending on manufacturer) followed by a booster dose at age 12-15 months. However, the number of doses required is governed by the child's current age and not the number of prior doses received. Unvaccinated children between the ages of 15 and 30 months are only required to have one dose of vaccine.

Hepatitis B- A minimum of 3 doses for all children born on and after January 1, 1994 (with at least 4 months spacing between the lst and 3rd dose).

Measles, Mumps, Rubella - A minimum of 2 measles, 1 mumps, and 1 rubella. (Most children receive 2 doses of each because the vaccine is usually given as MMR). First dose must be administered at age 12 months (365 days) or older. Second dose of measles vaccine does not have to be administered until age 4 to 6 years (at entry to kindergarten) but can be administered at any time after the minimum interval between dose 1 and dose 2. The minimum interval is one month (28 days).

*****FOR FURTHER INFORMATION, PLEASE CONSULT THE STATE BOARD OF HEALTH'S REGULATIONS FOR THE IMMUNIZATION OF SCHOOL CHILDREN, AUGUST 1,1995*****

NEW LEGISLATION EFFECTIVE JULY 1, 1999:

Varicella – All susceptible children born on and after January 1, 1997, shall be required to have a dose of chickenpox vaccine not earlier than 12 months (365 days).

Hepatitis B for 6th Graders – Beginning July 1, 2001, all children who have not received three doses of hepatitis B vaccine will be required to receive such immunization prior to entering the 6th grade.

NOTE: The following information is from: Commonwealth of Virginia State Board of Health. (1995). *Regulations for the Immunization of School Children*. Richmond, Va.: Virginia Department of Health.

CONDITIONAL ENROLLMENT: In order for a student to be CONDITIONALLY ENROLLED, the student must have proof of having received at least one (1) dose of each of the required immunizations (DTP, OPV, MEASLES, MUMPS, and RUBELLA) and have a schedule on file to receive the remainder of the required doses within 90 DAYS.

RELIGIOUS EXEMPTIONS: The student or his parent or guardian submits a CERTIFICATE OF RELIGIOUS EXEMPTION (FORM CRE-I), to the admitting official of the school to which the student is seeking admission. Form CRE-I is an affidavit stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. The CRE-1 must be signed by a NOTARY PUBLIC AND STAMPED WITH THE NOTARY'S SEAL.

MEDICAL EXEMPTIONS: The school must have written certification from a physician or a local health department on FORM MCH213C that one or more of the required immunizations may be detrimental to the student's health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.

If there are questions regarding immunizations please call your local health department or the Virginia Department of Health, Division of Immunization, at (804) 786-6246.

Reportable Diseases in Virginia

Disease Reporting and Control in Virginia. ***On January 6, 1999, a new version of the*** **Regulations for Disease Reporting and Control** ***went into effect. These regulations define the procedures by which disease surveillance, a critical component of the disease control process, is conducted in Virginia. Major changes to the regulations include (1) diseases added to the List of Reportable Diseases, (2) diseases removed from the List of Reportable Diseases, and (3) changes for laboratories. Among the additional notable changes to the*** **Regulations,** ***is the requirement for child care center directors to report outbreaks to the health department, as is required of schools.***

Those Required to Report. ***All physicians, directors of medical care facilities, and directors of laboratories must report persons diagnosed with any of the reportable diseases (Table 1) to the local health department. Persons in charge of*** **schools** ***and*** **day care centers** ***are required to report outbreaks. Reporting is usually accomplished by completing an Epi-1 form and mailing it to the local health department, although laboratories often use their own form for reporting.*** *The diseases listed in bold capital letters in Table 1, as well as outbreaks or any other unusual occurrence of disease, require rapid communication, such as by telephone.*

Excerpts from the **Regulation for Disease Reporting and Control,** ***Commonwealth of Virginia, State Board of Health, January 1999:***

12 VAC 5-90-90. Those Required to Report.

D. Person in Charge of a School or Child Care Center.

Any person in charge of a school or child care center shall report immediately to the local health department the presence or suspected presence in his school or child care center of children who have common symptoms suggesting an epidemic or outbreak situation. Any person so reporting shall be immune from liability provided by §32.1-38 of the Code of Virginia.

[Note: Please refer to the **Regulations** ***for a description of reporting requirements for physicians, directors of medical care facilities, and directors of laboratories.]***

VAC 5-90-10. Definitions.

"School" means i) any public school from kindergarten through grade 12 operated under the authority of any locality within the Commonwealth; ii) any private or parochial school that offers instruction at any level or grade from kindergarten through grade 12; iii) any private or parochial nursery school or preschool, or any private or parochial child care center licensed by the Commonwealth; and iv) any preschool handicapped classes or Head Start classes.

"Child care center" means a child day center, child day center system, child day program, family day home, family day system, or registered family day home as defined by §63.1-195 of the Code of Virginia, or similar place providing day care of children by such other name as may be applied.

"Epidemic" means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy.

"Outbreak" means the occurrence of more cases of disease than expected.

"Foodborne outbreak" means two or more cases of similar illness acquired through the consumption of food contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens food poisoning, hepatitis A, and Escherichia coli 0157:H7 illness.

Confidentiality. ***The health department protects the confidentiality of the information received, and anyone reporting information to the health department according to the provision of the regulations is immune from liability for so reporting.***

Ordering Information. ***To obtain a copy of the*** **Regulations for Disease Reporting and Control,** ***Commonwealth of Virginia, State Board of Health, January 1999, and reporting form (Form Epi-1, 11/98), please contact:***

Virginia Department of Health
Office of Epidemiology
P.O. Box 2448
Richmond, VA 23218
Telephone: 804-786-6261
Web site: http://www.vdh.state.va.us

Table 1. List of Reportable Diseases [132]

Acquired immunodeficiency syndrome (AIDS)	***Lyme disease***
Amebiasis*	***Lymphogranuloma venereum***
*ANTHRAX**	***Malaria****
Arboviral infection*	*MEASLES (Rubeola)**
*BOTULISM**	*MENINGOCOCCAL INFECTION**
Brucellosis*	***Mumps****
Campylobacter *infection**	***Ophthalmia neonatorum***
Chancroid*	*OUTBREAKS, ALL (including foodborne,*
Chickenpox	*nosocomial, occupational, toxic substance-*
Chlamydia trachomatis *infection**	*related, waterborne, and other outbreaks)*
*CHOLERA**	*PERTUSSIS (Whooping cough)**
Cryptosporidiosis*	*PLAGUE**
Cyclosporiasis*	*POLIOMYELITIS**
*DIPHTHERIA**	*PSITTACOSIS*
Ehrlichiosis	*RABIES, HUMAN AND ANIMAL**
Escherichia coli *O157:H7 and other* *enterohemorrhagic* E. coli *infections**	***Rabies treatment, post-exposure***
Giardiasis*	***Rocky Mountain spotted fever***
Gonorrhea*	***Rubella (German measles), including congenital rubella syndrome****
Granuloma inguinale	***Salmonellosis****
HAEMOPHILUS INFLUENZAE	***Shigellosis****
*INFECTION, INVASIVE**	***Streptococcal disease, Group A, invasive****
Hantavirus pulmonary syndrome	***Syphilis (report** PRIMARY and*
Hemolytic uremic syndrome (HUS)	*SECONDARY* **syphilis by rapid means)****
Hepatitis, Acute Viral	***Tetanus***
*HEPATITIS A**	***Toxic shock syndrome***
Hepatitis B*	***Toxic substance related illnesses***
Hepatitis C	***Trichinosis****
Other Acute Viral Hepatitis	*TUBERCULOSIS DISEASE* ***(MYCOBACTERIA *~)***
Human immunodeficiency virus (HIV) infection*	***Tuberculosis infection in children age <4 years***
Influenza *¶	***(Mantoux skin test reaction >10 mm)***
Kawasaki syndrome	***Typhoid fever***
Lead – elevated blood levels*	***Typhus***
Legionellosis*	***Vancomycin-resistant* Staphylococcus aureus****
Leprosy (Hansen disease)	**Vibrio *infection****
Listeriosis*	*YELLOW FEVER*

CONDITIONS LISTED IN CAPITAL AND BOLD LETTERS ***must be reported rapidly to the local health director or other professional employee of the department via telecommunication (e.g., telephone, telephone transmitted facsimile, telegraph, teletype, etc). Report all other diseases within seven days of diagnosis.***

**** These conditions are reportable by directors of laboratories. These and all other conditions are reportable by physicians and directors of medical care facilities as well.***

[132] Commonwealth of Virginia, State Board of Health. (1999, January). *Regulation for Disease Reporting and Control*, Web site: http://www.vdh.state.va.us/epi/list.htm

¶ Physicians and directors of medical care facilities should report influenza by number of cases only (and type of influenza, if available).

~ AFB on smear, speciation, and drug susceptibility

Blue Ribbon Commission Survey

Ratings: For your school health program, please provide success ratings for the goal items provided. Please use the following code to indicate your school's level of success: (3) High, (2) Moderate, or (1) Some to indicate your school's level of success. If your school does not have a program component to address this particular goal, check the (0) not addressed, no program, no service category

Factors: Also for each of the nine programs, consider what factors you feel contribute most to the overall success of your program and what problem factors keep you from accomplishing your goals. The following are examples of success and problem factors.

Success Factors: staff skills, excellent curriculum, excellent planning

Problem factors: not in improvement plan, low priority, inadequate materials

Item No.	**I. HEALTH EDUCATION -** Health Knowledge, Skill, and Behavior Improvement Areas Addressed by School's Instructional Programs	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	The school's health instruction program…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
1	Increases physical fitness knowledge and healthful behavior						
2	Increases consumer health knowledge and healthful practices						
3	Increase community and environmental health knowledge and healthful practices						
4	Improves conflict resolution skills						
5	Improves stress management skills						
6	Increase injury prevention knowledge and safe behavior skills						
7	Increases nutrition knowledge and healthful eating behavior						
8	Increases disease prevention and control knowledge and healthful behavior						
9	Increases knowledge of substance use/abuse and healthful behavior						
10	Increases human growth and development knowledge						

Item No.	**II. HEALTH SERVICES -**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	The school's health services program…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
11	Provides for early detection of health problems that can interfere with learning						
12	Provides information to families to facilitate access to primary health care services						
13	Provides expert handling of emergency crisis medical situations						
14	Provides record keeping needed to facilitate timely immunization of students						
15	Provides screenings for identifying student health deficits (e.g., vision, hearing, motor, and speech deficits) to ensure timely linkage to appropriate remediation services						
16	Provides monitoring of communicable diseases to prevent their spread						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	**III. HEALTHFUL SCHOOL ENVIRONMENT-** School Improvement Program	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	School maintenance and improvement efforts ensure…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
18	Safe physical plant (e.g., toxic substance management, building meets code requirements)						
19	Safe equipment (e.g., classroom and playground equipment)						
20	Safety of school area (e.g., crime prevention efforts, safety practices)						
21	Appropriate physical learning conditions (e.g., temperature, lighting, auditory conditions)						
22	Environment for meeting privacy needs in restrooms and locker rooms						

Item No.	**IV. PARENT/COMMUNITY INVOLVEMENT IN SCHOOL HEALTH PROGRAMS - Parent /Community Involvement Activities**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	School has…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
23	Consistent, proactive approaches for involving parents/families in all student health promotion programs						
24	Effective ways of communicating with parents about student and school health issues						
25	Cooperative ventures between the community and school to ensure health problems do not interfere with learning						
26	Student participation in community projects/programs designed to promote health						
27	Health curriculum support from community agencies and/or organizations						

Item No.	**V. SCHOOL COUNSELING PROGRAMS - School Counseling Service Goals**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	School counseling program…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
28	Helps students identify their educational goals						
29	Helps students identify their career goals						
30	Helps students identify their social goals						
31	Prepares students to function more effectively in the educational communities of their choice						
32	Provides services to help students resolve their developmental problems						

Item No.	**VI. PSYCHOLOGICAL AND SOCIAL SERVICES - Psychological and Social Service Linkages**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	School staff…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
33	Ensure that students showing early signs of social/psychological services are diagnosed						
34	Ensure that special needs students (disabled) have access to appropriate psychological and social services						
35	Ensure that students in crisis are linked with appropriate psychological and social services						
36	Facilitate linkages with case management services for students/families with complex psychological and social health needs						

Item No.	**VII. NUTRITION SERVICES - Nutrition Services**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	The school has…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
37	Meal time long enough to accommodate healthy eating habits for all children						
38	Meal time long enough to accommodate children with special feeding problems						
39	Balanced selections of foods that enable healthy eating practices at mealtime						
40	A nutrition program that provides a variety of healthy food choices to meet individual needs and preferences						
41	Nutritional drink and snack alternatives available in school's vending machines						
42	Staff trained to obtain/provide modified meals and nutrition support for children with special needs						

Item No.	**VIII. HEALTH PROMOTION FOR STAFF - Health Promotion for Staff**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	School improves…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
43	Faculty and staff health by providing adequate smoke-free space						
44	Faculty and staff by providing access to lockers and exercise facilities						
45	Faculty and staff by providing them access to food choices						
46	Faculty and staff by providing health promotion (wellness) programs						
47	Faculty and staff health by having a staff wellness program that spans the entire school year						
48	Faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	**IX. PHYSICAL EDUCATION - Physical Education Program**	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
	The school's physical education program…	High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
49	Helps students develop life skills to promote optimal health						
50	Promotes the physical fitness of all students						
51	Promotes in-class benefits for all students						
52	Accommodates the special needs of all students						